RELIABLE PROSTHETICS AND ORTHOTICS, LLC.

1505-C SOUTH GLENBURNIE RD. NEW BERN, NC 28562 *P: 252-638-8989 / F: 252-638-5989*
12 OFFICE PARK DRIVE, JACKSONVILLE, NC 28546 *P: 910-353-9002 / F: 910-353-9003*
229 PROFESSIONAL CIRCLE, MOREHEAD CITY, NC 28557 *P: 252-773-0046 / F: 252-773-0086*

_____
FIRST MI LAST

DOB: _____/_____/_____ SSN: _____-_____-_____

_____
ADDRESS CITY STATE ZIP

_____ _____ _____
HOME PREFERRED? ☐ CELL PREFERRED? ☐ WORK

MASK PREFERRED? ☐ Yes / ☐ No _____
SHOE SIZE HEIGHT WEIGHT AGE GENDER

REFERRAL INFORMATION:

(Required) Prescribing Physician: _____ Phone:( )_____

Primary Physician: _____ Phone:( )_____

Diabetic Physician: _____ Phone:( )_____

INSURANCE INFORMATION: ***(MUST BE COMPLETED BY PATIENT)***

Primary Insurance: _____ Policy #: _____

Policy Holder: _____ Policy Holder's DOB: _____/_____/_____

Secondary Insurance: _____ Policy #: _____

Policy Holder: _____ Policy Holder's DOB: _____/_____/_____

Tertiary Insurance: _____ Policy #: _____

Policy Holder: _____ Policy Holder's DOB: _____/_____/_____

Have you received a similar item in the past 5 years? *Yes* _____ *No*_____

Workers Comp. Injury? Claim #: _____

(All are required for services) **Contact:** _____ **Phone:** _____

AUTHORIZED TO RELEASE MEDICAL INFO TO: _____

_____
SIGNATURE **DATE**

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PATIENT ACKNOWLEDGEMENT

Please Review, Initial each Section, and Sign when Complete

_____ I Consent for treatment, Release of Medical Information & Acknowledgement of Financial Responsibility & Acknowledgment of Posted Notice of Privacy Practices:

_____ I, the undersigned, do hereby consent to treatment under the recommendations and instructions of the Orthotist / Prosthetist. I authorize any holder of medical or other information about me to release such information as may be necessary for the completion of my treatment. A photocopy of this authorization is to be considered valid.

_____ I understand that I am personally responsible for all copayments, deductibles, and/or payments for services on claims which insurance benefits may be limited or non-existent. By consenting to the procedure prescribed by my physician, and due to the inherent cost associated with custom fabrication, I understand that there can be no refund for a custom fabricated Orthosis / Prosthesis, unless the item is proved to be substandard (less than full quality) or inappropriate at the time of fitting. By my signature below, I acknowledge that I have received the Notice of Privacy Practices, Patient Bill of Rights and Medicare Supplier Standards provided by the company.

_____ I understand that if I do not provide my updated insurance information, referring physician information, or if I provide any other incomplete or inaccurate information on the demographic sheet, I will be responsible for the payment for the device(s)/service(s) provided to me.

_____ If I have not had a face-to-face encounter with my doctor to obtain a prescription prior to receiving services (preferably within 3 months), I will have to make a new appointment with my doctor and obtain a prescription prior to receiving services.

_____ ***For Medicare Patients*** I understand that due to Medicare guidelines, a Standard Written Order will be generated following my services today. This will be sent to my prescribing physician for signature approval. A copy of the physician's notes will also be necessary in order to fulfil the claim requirements set forth by Medicare. **IF THE INFORMATION IS INNACURATE, DOES NOT CONSTITUTE MEDICAL NECESSITY, OR DOES NOT REFLECT THE PRESCRIPTION/SERVICE I AM HERE TO RECEIVE**, it will be my responsibility as the patient to make another appointment with my doctor to review the criteria necessary for Medicare to cover the device. I will request a copy of the Medicare LCD (Local Coverage Determination) Policy Article to review the requirements, as needed. Reliable Prosthetics and Orthotics, LLC is required by Medicare for furnish an applicable ABN (Advance Beneficiary Notice of Non-Coverage) if it is possible that Medicare will deny the claim due to the above required documentation being missing, incomplete, or inaccurate.

SIGNATURE **DATE**

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INTAKE QUESTIONAIRE

The following questions are relating to the service(s) you are visiting us for. Please answer to the best of your ability. If you feel a section does not apply to you, please put "N/A".

1. Patient Name: _____

2. Have you recently been in contact with anyone with a COVID diagnosis? yes no

4. Current pain level: **1 2 3 4 5 6 7 8 9 10**

5. When did injury/symptom occur? _____

6. What activity caused your injury? _____

7. What are your symptoms? _____

8. What activities increase your pain level? _____

9. Have you had any surgical procedures pertaining to your visit today? If "yes", please explain: _____

_____

10. Any additional necessary info that pertains to your visit: _____

_____

_____

SIGNATURE **DATE**